STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
www.tennessee.gov/health

TENNESSEE BOARD OF NURSING

Local (Nashville Calling Area) 615 -532-3202
Nationwide (toll free) 1-800-778-4123, ext. 25166

ADVANCED PRACTICE NURSE INSTRUCTIONS/APPLICATION

It takes approximately 6 weeks for a certificate to be issued. If additional information is required you will be notified by mail. It is not necessary to call the board to check on the status of your application. Go to www.tennessee.gov/health, click on verification.

To apply for state certification, submit the following:

1. **ORIGINAL APPLICATION** Complete **all** sections.

2. **Affix one (1) recent professional passport type (2½" x 2½") photograph.**

a) Vending machines, snapshots or ID photographs are not acceptable.
b) Straight on pose including head and shoulders.
c) Legal signature on front of photograph - signature must not conceal face.

3. **Sign Affidavit at the bottom of page 3 in the presence of a Notary Public.**

4. **Please have page 4 completed by the Dean, Director or Chairman of Graduate Program**

5. **Provide an official nursing transcript, conferring advanced nursing practice. (e.g. MSN, Ph.D.) Forward directly to the Board of Nursing.**

6. **Provide an official verification of current certificate from national certifying body (e.g. ANCC, AANP, NBCRNA) Forward directly to the Board of Nursing.**

7. **Mandatory Practitioner Profile Questionnaire with your application.**

8. **Declaration of Citizenship (with required documentation) Sign Affidavit in the presence of a Notary Public**

9. **CERTIFICATE FEE***

Attach the correct fee in U.S. currency. **Check or money order must be made payable to the Tennessee Board of Nursing. *FEES SUBMITTED TO THE BOARD ARE NOT REFUNDABLE**

a.	Certificate Fee	$200.00
b.	State Regulatory Fee	10.00
		$210.00

APPLICATION COMPLETION CHECKLIST:

		YES	NO
1.	Original page from Dean, Director or Chairman of Graduate Program Completed	❒	❒
2.	Completed application form (notarized)	❒	❒
3.	Advanced Practice Certification Fee ($210.00)	❒	❒
4.	Passport type photograph – signed on front	❒	❒
5.	Request official advanced practice nursing transcript	❒	❒
6.	Request official verification from national specialty certification	❒	❒
7.	Mandatory Practitioner Profile Questionnaire attached (mail with application)	❒	❒
8.	TN/Multi-state copy of current license (internet copy ok)	❒	❒
9.	Declaration of Citizenship (**all applicants must have notarized**) with required documentation	❒	❒
10.	Requested court record records (if applicable).	❒	❒

Please allow 4-6 weeks for processing (no phone call please, this will slow down the process)

If you change your address, it is your responsibility to notify this office or go to www.tennessee.gov/health.

If you change your name, you must submit a copy of the legal document that changed your name. Fax to (615) 741-7899.

Please contact the Board if you have not received a notification after six (6) weeks from the date your check has been redeemed by your financial institutions.

Board phone number: 1-800-778-4123 extension 25166; local, 615-532-5166.

PASSPORT TYPE
PHOTOGRAPH
NOT TO EXCEED
2½" x 2½ "

TAPE PHOTOGRAPH HERE
SIGNED ON THE FRONT BY
APPLICANT

Tennessee Board of Nursing
665 Mainstream Drive
Nashville, TN 37243

1702/ 001-$200.00
006-$ 10.00

FEES ARE NOT REFUNDABLE

APPLICATION FOR CERTIFICATE AS AN ADVANCED PRACTICE NURSE

HAVE YOU EVER BEEN LICENSED AS AN ADVANCED NURSE IN TENNESSEE? ❒ YES ❒ NO
IF YES, CONTACT THIS OFFICE FOR A REINSTATEMENT APPLICATION. DO NOT COMPLETE THIS FORM.

TO BE COMPLETED IN INK BY APPLICANT. PLEASE REFER TO INSTRUCTION SHEET WHEN COMPLETING THE APPLICATION PRINT OR TYPE. ALL QUESTIONS MUST BE COMPLETED.

PART 1 PERSONAL INFORMATION

1. Name _____
LAST FIRST MIDDLE MAIDEN

2. List any other names by which you have been known _____
LAST FIRST MIDDLE

3. Mailing Address: _____
(Street/PO Box) (City/State/Zip)
Street Address: _____
(required if Mailing Address is a PO Box Street (City/State/Zip)

4. Social Security Number _____ Telephone Number _____ _____ _____
HOME OFFICE MOBILE
Your social security number may be used to verify your identify and for any other purpose allowed by state of federal law.

5. U.S. Citizenship: ❒ YES ❒ NO All applicants **must** complete the attached Declaration of Citizenship.

6. Do you wish to receive notification, including renewal notification, from the Department of Health via email? ___Yes
___No
Email Address: _____

7. Tennessee RN License Number _____ Date of Birth _____ Gender: ❒ Female ❒ Male

If practicing in Tennessee on the multistate privilege, list state and license number _____

8. Ethnic Group: ❒ White ❒ Black ❒ Native American Indian ❒ Asian ❒ Hispanic ❒ Other, Specify _____

9. **PRIMARY STATE OF RESIDENCE**

I declare that my primary state of residence is _____. This state is referred to as my home state under the Nurse Licensure Compact and means that it is my declared fixed permanent and principle home for legal purposes and is my domicile. **The following items may be requested as proof of primary state of residence: driver's license, voter registration card, federal income tax return.** If you indicated another compact state as your primary state of residence, but will be moving to Tennessee and declaring Tennessee as your primary state of residence please indicate:
YES ❒ and date of move to Tennessee _____

PART 2 ADVANCED PRACTICE NURSE CERTIFICATION INFORMATION

10. **Advanced Practice Nursing Education:**

10.1 _____ 10.2 Degree ❒ Certificate ❒ Diploma ❒ Baccalaureate
Name of College/University/School of Nursing ❒ Masters ❒ Post-Masters ❒ Doctorate

Location _____
CITY STATE
Length of Program _____ Date of Enrollment _____ Completion Date _____

11. **Disciplinary Action**

11.1 Have you ever had a nursing license (RN or APN) certification or any other professional license, certificate, privilege or registration disciplined (revoked, suspended, placed on probation or reprimanded) or voluntarily surrendered in any state or jurisdiction?
❒ YES ❒ NO

11.2 If **yes**, please identify the state where the action was originally taken _____
State

12. Are you currently in good physical and mental health? (Include any physical or mental limitations) ❒ Yes ❒ No If **no**, please explain: _____

13. **Conviction of a Crime**

13.1 Have you ever been convicted or pled guilty to a misdemeanor or felony other than a minor traffic violation? ❒ Yes ❒ No
If **yes**, please submit a certified copy of the warrant and judgment or conviction papers and evidence of completion of fines, restitution, probation, and a self letter that describes circumstances that resulted in arrest and conviction.

13.2 If **yes**, specify date and type of conviction.

Date _____ Type of Conviction _____
Month/Day/Year

14. What is your activity (practice) status in the nursing profession?
(practice in this profession also includes teaching, administration and research). **Check only one.**

- ❒ = Practicing Nursing full time (1)
- ☐ = Practicing Nursing part time (2)
- ☐ = Not practiced Nursing for less than 2 years (3)
- ☐ = Not practiced Nursing for at least 2 years but less than 5 years (4)
- ☐ = Not practiced Nursing for 5 years or more (5)
- ☐ = Official Use Only (6)

15. Please indicate what your major practice area in nursing will be or if unknown check other: **Check Only One**

- ☐ = Community/Public Health (1)
- ☐ = General Practice (2)
- ☐ = Geriatric (3)
- ☐ = Obstetric/Gynecologic (4)
- ☐ = Medical/Surgical (5)
- ☐ = Pediatric (6)
- ☐ = Psychiatric/Mental Health (7)
- ☐ = Critical/Intensive Care (8)
- ☐ = Emergency Service (9)
- ☐ = Case Management (11)
- ☐ = Primary Care (12)
- ☐ = Education (13)
- ☐ = Administrative/Management (14)
- ☐ = Perioperative/Anesthesia (15)
- ☐ = Pain Management
- ☐ = Other, Please Specify (10) _____

16. Please indicate what your principal setting of Employment will be or if unknown check other: **Check Only One**

- ☐ = Hospital/Medical Center (1)
- ☐ = Ambulatory/Outpatient,Clinic, Surgery Center (2) FreeStanding
- ☐ = Office/Clinic (3)
- ☐ = Nursing Home (4)
- ☐ = Home Health (5)
- ☐ = Private Duty (6)
- ☐ = Insurance (7)
- ☐ = Industrial/Occupational (8)
- ☐ = Community/Public Health (9)
- ☐ = Military/Federal (16)
- ☐ = Hospice (13)
- ☐ = School Nurse (11)
- ☐ = School of Nursing/College/ University (12)
- ☐ = Assisted Living/Home for the Aged (15)
- ☐ = Other, Please specify (10) _____

17. Please indicate what your current type of nursing position will be: **Check Only One**

- ☐ = Nurse Anesthetist (Certified) & (17) (Certificate of Fitness to Prescribe)
- ☐ = Nurse Anesthetist (9)
- ☐ = Nurse Practitioner (7)
- ☐ = Nurse Practitioner (Certificate of Fitness to prescribe) (12)
- ☐ = Clinical Specialist (8)
- ☐ = Clinical Specialist (Certificate of Fitness to prescribe) (13)
- ☐ = Nurse Midwife (Certified) (10)
- ☐ = Nurse Midwife (Certificate of Fitness to prescribe) (14)

18. Please indicate your highest degree in nursing: **Check Only One**

- ☐ = Diploma (1)
- ☐ = Associate degree in Nursing (2)
- ☐ = Bachelors in Nursing (3)
- ☐ = Masters in Nursing (4)
- ☐ = Doctorate in Nursing (5)

19. Please indicate your highest degree in another field, if applicable: **Check Only One**

- ☐ = No Other Degree Held (6)
- ☐ = Associate (7)
- ☐ = Bachelors (8)
- ☐ = Masters (9)
- ☐ = Doctorate (10)

AFFIDAVIT

State of _____

County of _____

_____ personally appearing before me, being duly sworn says that _____

NAME OF APPLICANT he/she

is the person referred to in the foregoing application for a certificate to practice as an Advanced Practice Nurse in the State of Tennessee

that the statements therein contained are true and that _____ has read and understands this affidavit. **I understand** he/she

that if the processing of this application is not completed, the application becomes null and void one year from date received. I also understand that falsification of an application is grounds for denial of licensure or discipline against a license.

I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

Legal Signature of Applicant _____

Sworn to before me this _____ day of _____, 20 _____

Notary Public _____

SEAL Commission Expires _____

PART 3 ADVANCED PRACTICE CERTIFICATE SPECIALTY PROGRAM INFORMATION

TO BE COMPLETED BY DEAN, DIRECTOR OR CHAIRMAN OF GRADUATE PROGRAM

I hereby certify that _____ was awarded a ❒Certificate ❒ Diploma ❒Master
Name ❒ Post-Master ❒ Doctorate

in nursing dated _____. The nursing specialty was ❒ Nurse Practitioner ❒ Nurse Anesthetist

❒ Nurse Midwife ❒ Clinical Nurse Specialist.

SCHOOL SEAL

Signed _____ R.N.Dean/Director

Graduate/Specialty Program _____

Date _____

Name of School _____

PART 4 APPLICATION FOR A CERTIFICATE OF FITNESS TO PRESCRIBE AND OR ISSUE LEGEND DRUGS

DO NOT APPLY IF YOU HAVE EVER BEEN ISSUED A TENNESSEE CERTIFICATE OF FITNESS TO PRESCRIBE

TO BE COMPLETED BY DEAN, DIRECTOR OR CHAIRMAN OF GRADUATE PROGRAM

I hereby certify that _____ was awarded a _____
(Name)

Nursing degree dated _____.

The program included three (3) quarter hours of pharmacology or its equivalent. Yes ____ ___ No _____

SCHOOL SEAL

Signed _____ R.N.Dean/Director

Graduate Program _____

Date _____

Name of School _____

Office use only

Name	License Number	Issue Date

DM/G4014056/BN

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

DECLARATION OF CITIZENSHIP
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a (n) _____ _____.
Healthcare Profession (Please Print) License number if applicable

Please Print Legibly

1. Name: _____
   Last First Middle Maiden_
2. Mailing Address: _____
   _
3. Phone Number: Home: (____) _____-_____ Office: (____) _____-_____ Fax: (____) ___-_____
4. I am a United States Citizen: ____Yes ____No
5. I am a foreign national not physically present in the United States _____Yes _____No.

   If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.

6. Applicants Claiming United States Citizenship **MUST** provide one of the following:

   a) Tennessee Driver's License, or photo ID issued by Department of Safety.
   b) A valid driver license or ID issued by another state provided its issuance requirements meet Department of Safety criteria.
   c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not count.
   d) A federally issued birth certificate.
   e) A valid, unexpired U.S. passport.
   f) A report of birth abroad of a U.S. citizen.
   g) A certificate of citizenship.
   h) A certificate of naturalization.
   i) A U.S. citizen ID card.
   j) Any successor document to #'s a-i above.
   k) SSN that the entity or local health department may verify with the Social Security Administration in accordance with federal law.

7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)

a) Permanent Residents
b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
d) Refugees who meet the qualifications set out in 8 U.S.C. 1157
e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d) (5) or whose deportation has been withheld under 8 U.S.C. 1253.
f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a) (7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c) (2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F (1) student status– "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this _____ day of _____, 20__.

_____
Signature

Sworn to before me this _____day of _____, 20__.

_____ AFFIX SEAL HERE
NOTARY PUBLIC

My Commission Expires: _____

If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of U.S. citizenship, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney.

TENNESSEE DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER

PROFILE QUESTIONNAIRE FOR

LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, et seq., requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license. The professions required to submit a profile questionnaire are:

Advanced Practice Nurses
Alcohol and Drug Counselors
Audiologists
Chiropractic Physicians
Clinical Pastoral Therapists
Dentists
Dietitian/Nutritionists
Dispensing Opticians
Electrologists
Licensed Registered Respiratory Therapists
Licensed Certified Respiratory Therapists
Licensed Laboratory Personnel
Marital & Family Therapists
Massage Therapists
Medical Doctors
Nursing Home Administrators
Occupational Therapists
Optometrists
Orthopedic Physician Assistants
Osteopathic Physicians
Pharmacists
Physician Assistants
Physical Therapists
Podiatrists
Professional Counselors
Psychologists
Respiratory Care Assistants
Social Workers
Speech Language Pathologists
Veterinarians

A blank copy of the profile questionnaire may be obtained from the following web site address: http://health.state.tn.us/Downloads/g6019027.pdf.

INSTRUCTIONS

QUESTIONNAIRE DEADLINE The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form. Changes to the questionnaire must be submitted within 30 days of the change.

COMPLETING THE QUESTIONNAIRE Complete the questionnaire by typing the information or by printing neatly in block letters in ball point pen. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

SUBMITTING THE QUESTIONNAIRE Mail the completed profile questionnaire to:

Tennessee Board of *(board for your profession)*
Healthcare Provider Information
665 Mainstream Drive
Nashville, TN 37243

- **Do not return pages 1 through 4 with the questionnaire to the department.**
- **Keep a copy of the questionnaire for your records.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete Part I, noting the following:

- License number: Fill in your Tennessee license number and indicate your profession in the space provided. **If you have not been issued a license number, please leave this blank.**
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Primary Practice Address: Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There is a box to check in Part I to request this. Retirees: Write in "N/A" for practice address. If you do not have a practice address at the time of completing this questionnaire, you must report your practice address within 30 days of obtaining a practice address.
- Supervising Physician: Physician assistants and advanced practice nurses must list all supervising physicians. In addition, advanced practice nurses must also complete the Notice and Formulary if you are prescribing. The Notice and Formulary is available online at http://health.state.tn.us/boards/Nursing/applications.htm.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a "yes" or "no" response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

A. List all hospitals at which you hold staff privileges. The definition for "hospital" can be found at T.C.A. § 68-11-201.

VI. MANAGED CARE AND TENNCARE PLANS

A. In the spaces provided, answer information about the Managed Care plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

B. In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

VII. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal's period expired, or that the applicable board issued an agreed order or consent decree.

In the "Description of Violation" spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the "Description of Action" spaces, indicate the type of disciplinary action imposed against your professional license such as censure, reprimand, probation, etc.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer "yes" to any of the questions regarding Final Disciplinary Actions and/or Criminal Offenses and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions B and C in Part VII in their entirety before answering those questions.

VIII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

IX. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.

A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below $75,000 are not required to be submitted.
B) For Chiropractors, judgments or settlements below $50,000 are not required to be submitted.
C) For Dentists, judgments or settlements below $25,000 are not required to be submitted.
D) For all other professions, judgments or settlements below $10,000 are not required to be submitted.

Pending malpractice claims are not required to be reported unless/until final adjudication against you.

X. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____

Profession _____

TENNESSEE BOARD OF *(board for your profession)*
HEALTHCARE PROVIDER INFORMATION
TENNESSEE DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSION: _____ LICENSE NUMBER: _____

B. SOCIAL SECURITY NUMBER: _____ **(This will not be published)**.

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):

CURRENT NAME:

(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

(LAST) (FIRST) (MIDDLE)

(LAST) (FIRST) (MIDDLE)

D. PRIMARY PRACTICE ADDRESS (attach additional sheets if necessary):

(PRACTICE NAME)

(STREET NUMBER AND NAME)

(CITY) (STATE) (ZIP CODE)

☐ Check here if your primary practice address is your home address and you want it to be published as part of the profile and on the web site.

E. E-MAIL ADDRESS: _____ ☐
Your e-mail address will be published unless you elect not to by checking here.

F. WEB PAGE ADDRESS: _____ ☐
Your web page address will be published unless you elect not to by checking here.

G. PRACTICE TELEPHONE: (_____) _____ ☐
Your telephone number will be published unless you elect not to by checking here.

H. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____ 2. _____

I. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or advanced practice nurse) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____

2. _____

Practitioner's Name _____ **License #** _____

Profession _____

II. GRADUATE/ POSTGRADUATE MEDICAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/COUNTRY	DATE OF GRADUATION MM/DD/YYYY	TYPE OF DEGREE
1.			
2.			
3.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE,COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			

III. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES ❑ NO ❑

(Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

Practitioner's Name _____ **License #** _____

Profession _____

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❑ NO ❑

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❑ NO ❑

If "YES", list the title of the appointment, name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(9)) YES ❑ NO ❑

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

NAME OF HOSPITAL	CITY/STATE
1.	
2.	
3.	
4.	
5.	

VI. MANAGED CARE PLANS

A. Do you participate in any managed care plans? (Authority: T.C.A. §63-51-105(a)(15)) YES ❑ NO ❑

If "YES", list each: (Attach additional sheets, clearly labeled with this question number, if necessary)

NAME OF MANAGED CARE PLAN
1.
2.
3.
4.
5.

Practitioner's Name _____ **License #** _____

Profession _____

B. Do you currently participate in and accept any TennCare plan(s) as a provider? YES ❑ NO ❑

If "YES", list each plan in which you currently participate or accept as a provider: (Authority: T.C.A. § 63-51-105(a)(16))

NAME OF TENNCARE PLAN

1. _____
2. _____
3. _____
4. _____
5. _____

VII. FINAL DISCIPLINARY ACTION (See Instructions):

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❑ NO ❑

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

Practitioner's Name _____ **License #** _____

Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted or reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❑ NO ❑

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A.: § 63-51-105(a)(4))

YES ❑ NO ❑

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF ACTION
1.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

Practitioner's Name _____ **License #** _____

Profession _____

VIII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-51-105(a)(1)) YES ❑ NO ❑

If "YES" briefly describe the offense(s):

	DESCRIPTION OF OFFENSE(S)	DATE	JURISDICTION
1.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

2.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❑ NO ❑

IX. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. § 63-51-105(a)(5)) YES ❑ NO ❑

If "YES", indicate a brief description of the nature(s) of the claim, the date(s) of the claim report(s), and the amount of the judgment(s), award or settlement(s):

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		
4.		

Practitioner's Name _____ **License #** _____

Profession _____

X. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-51-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-51-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-51-113 and/or 63-51-118.

_____ Date: _____

(Signature of Provider)

REMINDER: Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law.

TENNESSEE BOARD OF NURSING
Continuing Competence Requirements for
Advanced Practice Nurses, Registered Nurses and Licensed Practical Nurses
Rule 1000-01-.14, 1000-02-.14 and 1000-04-.05

Continued competence is defined as "the application of integrated nursing knowledge and the interpersonal, decision-making, psychomotor, communication, and leadership skills expected for the nursing practice role within the context of the public health, safety, and welfare."

Advanced Practice Nurses

In order to have acceptable proof of competence, advanced practice nurses must have documentation of:

1. **Evidence of initial or continuing national certification.**
2. **One additional item from the Registered nurse proof of competence below.**

Advanced Practice Nurses that are holders of a Certificate of Fitness must have documentation of:

1. **Evidence of initial or continuing national certification.**
2. **A minimum of one (1) contact hour course addressing controlled substance prescribing practices offered through a continuing education provider approved by any nationally certifying board of an advanced practice nurse.**
3. **One additional item from the Registered nurse proof of competence below.**

Registered Nurses and Licensed Practical Nurses

Acceptable proof of competence shall include <u>two</u> items documentation of the following:
(<u>one</u> item for nurses not practicing but wishing to maintain an active license, contact hours must be ten hours which includes five for each year out of practice)

1. **Copy of a satisfactory employer evaluation**
2. **Letter from a peer providing a satisfactory evaluation of your nursing performance**
3. **Letter from a patient or family member giving evidence of a satisfactory nurse/patient relationship**
4. **Copy of a contract of renewal or re-appointment to a nursing position**
5. **Written self-evaluation based on the standards of competence listed in the rules**
6. **Evidence of initial or continuing national certification**
7. **A document that identifies two nursing goals and how you met these goals**
8. **A letter from the agency where you volunteered as a nurse**
9. **Documentation from a school of nursing stating that you participated in the education of nursing students**
10. **Certificate/evidence of five contact hours of continuing education.**
11. **Copy of an article published relevant to nursing**
12. **Letter of satisfactory completion of a nursing refresher course**
13. **Letter of satisfactory completion of a comprehensive nursing orientation program**
14. **Official transcript (may be student issued) demonstrating two hours of nursing credit**
15. **Evidence of successfully retaken NCLEX**

Each licensee must maintain evidence of compliance for four years from when the requirements are completed. This documentation must be produced for inspection and verification within thirty days of a written request by the board. Failure to either complete the continued competence activities or to falsely certify completion may subject the nurse's license to disciplinary action.